

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATIONFORM APPROVED
OMB NO. 0938-0193**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL****FOR: HEALTH CARE FINANCING ADMINISTRATION**TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:

02-16

2. STATE

NC

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

October 1, 2002

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447-201

7. FEDERAL BUDGET IMPACT:

a. FFY 03 (\$3,001,008)

b. FFY 04 (\$3,091,038)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D, Page 8

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4.19-D, Page 8

10. SUBJECT OF AMENDMENT:

Payments for Nursing Facility services

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED: Not Required

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Carmen Hooker Odom

14. TITLE:

Secretary

15. DATE SUBMITTED:

December 23, 2002

16. RETURN TO:

Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

10/31/02

18. DATE APPROVED:

3/24/03

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

10/1/02

20. SIGNATURE OF REGIONAL OFFICIAL:

Bumby Smith

21. TYPED NAME:

CHARLENE BROWN

22. TITLE:

Deputy Director, CM50

23. REMARKS:

Medical Assistance
State: North Carolina

Payment for Services – Prospective Reimbursement Plan for Nursing Care Facilities

- (E) The sum computed for each category in (c)(4)(D) of this Section shall be the price level adjustment factor for that category of rates (direct or indirect) for the coming fiscal year.
 - (F) However, effective October 1, 1997 for fiscal year 1998, the price level adjustment factors calculated in (c)(4)(E) of this Section shall be adjusted to 2.04% for direct rates and 1% for indirect rates, in order to produce fair and reasonable reimbursement of efficient operators.
 - (G) If necessary, the Division of Medical Assistance shall adjust the annual price level adjustment factor or rates in order to prevent payment rates from exceeding upper payment limits established by Federal Regulations.
 - (H) Notwithstanding any other provision, if specified these rates will be adjusted as shown on Attachment Supplement 1, Page 1 of the state plan.
- (d) The skilled and intermediate direct patient care rates for new facilities are established at the lower of the projected costs in the provider's Certificate of Need application inflated from the projected opening date in the Certificate of Need application to the current rate period in which the facility is certified based on the price changes as set forth in Rule .0102(c) or the average of industry base year costs and adjusted for price changes as set forth in Rule .0102(c) of this Section. A new facility receives the indirect rate in effect at the time the facility is enrolled in the Medicaid Program. In the event of a change of ownership, the new owner receives the same rate of payment assigned to the previous owner.

TN. No. 02-16
Supersedes
TN. No. 01-15

Approval Date: MAR 24 2003

Eff. Date 10/01/02

Medical Assistance
State: North Carolina

Payment for Services – Prospective Reimbursement Plan for Nursing Care Facilities

Payment for Nursing Care Facility Services:

FY 2003 – No adjustment

TN. No. 02-16
Supersedes
TN. No. New

Approval Date MAR 24 2003

Eff. Date 10/01/02